Temporary Impairments Documentation Form

Student Name: ___________________________ DOB: _______ / _______ / _______ has requested disability support services from the Office of Disability Services for Students (DSS) at Indiana University Bloomington (IUB) in regard to a temporary impairment. Temporary impairments lasting less than 6 months are not covered under the Americans with Disabilities Act. However, DSS will assist students and facilitate communication with instructors about academic modifications. Documentation provides vital information about the functional limitation of the student’s disability and its impact in a post-secondary academic environment.

Please complete all sections of this form and return it as soon as possible so that we may verify the student’s eligibility for services. Providers may also use their own documentation format as long as all of the information requested below is included; if this information is not provided, services may be delayed as DSS obtains clarification. Please call 812-855-7578 if you have questions. The completed form may be faxed to 812-855-7650 or it may be mailed to the address at the bottom of this page. DSS welcomes any additional documentation you would like to include.

Diagnosis:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Date of diagnosis: _____ / _____ / _____ Last Appointment: _____ / _____ / _____

Basis on which diagnosis was made:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Clinical manifestations/symptoms:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Current medical treatment that may affect the student in the higher education environment.
___________________________________________________________________________________________
___________________________________________________________________________________________

Will crutches, a walker or a temporary wheelchair be required? _____ If yes, duration of use:

How long do you estimate the condition impacting academic achievement?
☑ # of days _______ ☐ # of weeks _______ ☐ # of months _______
Updated documentation will be provided after next appointment on ____/____/____

Prescribed medication and the side effects that impact academic functioning:
___________________________________________________________________________________________
___________________________________________________________________________________________

Additional comments and recommended auxiliary support, strategies, or service that may be beneficial to the student in the higher education environment.
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Certifying Professional
Name (print): _________________________________________________________ Date: ____/____/____
Profession: ______________________ License number: ______________________
Office Address: _____________________________________________________________________________
Phone: ______________________ Fax: ______________________ Email Address: ______________________
Certifying Professional Signature: _____________________________________________________________